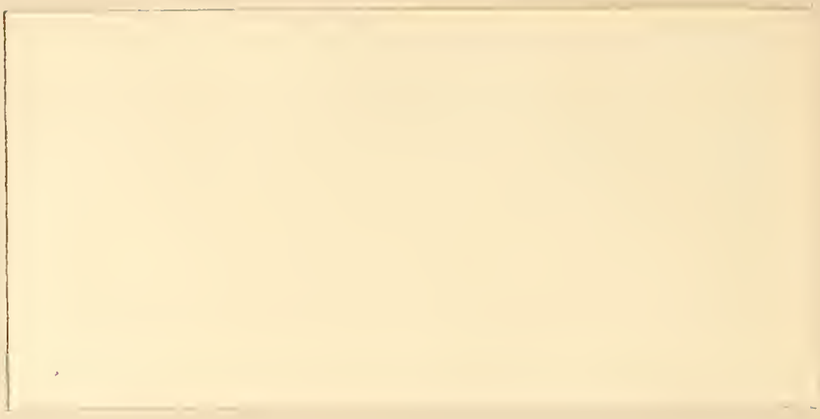
Legislative Snapshot:
Number 21

MALPRACTICE

THE INTERGOVERNMENTAL
TH POLICY PROJECT



THE
GEORGE
WASHINGTON
UNIVERSITY
Washington, D.C. 20006

Intergovernmental Health Policy Project
Suite 505
1919 Pennsylvania Avenue, N.W.
(202) 872-1445

MALPRACTICE

by
Peter E. Carlin

Preparation of this paper was supported by
The Office of Research, Demonstrations and Statistics (ORDS),
Health Care Financing Administration,
Department of Health and Human Services
(HCFA Grant #18-P-97321/3-03

IHPP is a clearinghouse for state health legislation.
The project publishes *State Health Notes* and research reports on state health policy.
IHPP is affiliated with the National Health Policy Forum.

MALPRACTICE

A Snapshot of 1980 State Laws

Peter E. Carlin

In the mid-1970s, nearly every state experienced a medical malpractice "crisis." Precipitated by the reluctance of some insurance companies to write liability insurance, and exacerbated by the rise in premiums demanded by those carriers who continued to issue policies, the malpractice "crisis" threatened the fabric of health care in America.

The realization that the health care system was on the verge of collapse spurred a host of groups to place intense pressure on state officials to address the abuses and shortcomings endemic to the existing malpractice system. The response to the "crisis" was a flurry of legislative activity during these years. State legislatures enacted many new statutes designed to stabilize insurance markets, modify traditional tort laws, and introduce new procedures for resolving medical malpractice disputes. Although the exact nature of that legislative response varied according to the specific problems, constitutional limitations, and political traditions and realities of each state, virtually every legislature passed at least one major malpractice statute between 1975 and 1978.

If 1975 is employed as a benchmark year for malpractice legislation, then the bulk of these new laws tended to fall in the following five areas:

1) establishment of study commissions authorized to investigate the underlying causes of the medical malpractice "crisis";

2) creation of alternative insurance mechanisms to guarantee the availability of liability insurance;

3) substantive modifications in civil practice laws as they related to medical negligence;

4) improvements in programs to ensure quality medical care; and

5) development of arbitration and screening processes aimed at encouraging pretrial settlements and fostering more equitable claims procedures for all parties.

The burst of legislative activity that characterized the 1975 response has abated somewhat, although states continue to enact a variety of new laws. The past few years have witnessed the passage of many new statutes in an effort to iron out existing problems. This limited but highly significant activity is reflected in the medical malpractice legislation of 1980, when 17 states enacted a total of 24 new laws relating to different areas of malpractice. While several of these statutes made only minor changes in existing legislation, the bulk of these 1980 laws were concerned with amending legal procedures intrinsic to any malpractice action and with regulating the liability insurance market.

One of the most significant and controversial developments to emerge out of the 1975 legislative activity was the creation of arbitration and screening mechanisms as alternatives to litigation. Both were adopted as quick and inexpensive mechanisms for resolving medical malpractice actions. Arbitration boards and screening panels provide a less formal setting and hearings generally take place before individuals familiar with the field of malpractice.

There are, however, functional differences between these two mechanisms. A screening panel determines whether or not a claim has sufficient merit to warrant proceeding to trial. In most states with this mechanism, participation is mandatory, but the findings of the panel are generally regarded as advisory to the courts. In contrast, the decision of the arbitration board is determinative on the courts although, with the exception of Puerto Rico, participation is voluntary and must be agreed to by both parties. Another difference between these two mechanisms is that most screening panels do not determine damages, while an award determination is generally part of an arbitration decision.

In 1980, several states passed legislation amending their panel statutes. For instance, because of the inability of its Medical Liability Mediation Panels to convene within the statutory time limit, a new **RHODE ISLAND** law now extends that prescribed period to 90 days from the date the action was first filed with the Superior Court. In addition, this amendment precludes any panel from issuing a finding if it cannot conduct a hearing within six months after both parties complete discovery proceedings. The panel, however, may request an extension if it can demonstrate "good cause" to the panel administrator.

TENNESSEE also enacted a 1980 law that amends the operations of its Medical Malpractice Review Board. Under this act, both parties may agree to waive a hearing before the Board. Furthermore, this act now stipulates that the Board must conduct a hearing within six months after an action has been filed with a circuit court and must render a decision within 30 days after a hearing. This statute also precludes the admissibility in evidence at a subsequent trial any statement made during the course of the Board hearing, although the Board's formal statement is admissible.

FLORIDA, one of four states to have its panel statute declared unconstitutional, enacted a 1980 law to discourage attorneys from filing dubious malpractice claims. Under this statute, a losing party in a malpractice case must pay the legal expenses of the prevailing party.

Concern over the availability of malpractice insurance was another area of legislative activity in 1980. **KANSAS**, for example, now requires any directors, trustees, administrators, or other officers of a medical care facility, mental health center or mental health clinic to obtain liability coverage. Another 1980 measure enacted in **KANSAS** established a plan to provide liability insurance to all health care providers who are unable to obtain malpractice coverage through ordinary methods.

In **PENNSYLVANIA**, a new 1980 law requires every health care provider to obtain professional liability coverage only from licensed or approved insurers. Under this act, a health care provider who conducts more than 50 percent of his or her practice in the state must now obtain insurance in the amount of $100,000 per occurrence and $300,000 per annual aggregate. Obtaining this basic liability coverage allows a health care provider or hospital ($100,000 per occurrence and $1,000,000 per annual aggregate) to participate in the State Medical Professional Liability Catastrophe Loss Fund.

Several states also passed 1980 legislation relating to their Joint Underwriting Associations (JUAs). JUAs were the most common legislative response to the malpractice insurance problem of the mid-1970s. Composed of all liability insurers in a particular state, JUAs were designed to compel companies to provide malpractice insurance by allowing them to pool their losses. Although adopted as interim solutions, many of the JUAs have been renewed for additional terms.

In 1980, a number of states enacted laws calling for the "orderly termination" of their state JUA. In **VIRGINIA**, for example, the JUA is directed to remain in existence solely to complete its dissolution and discharge its obligations. A new measure enacted by **CALIFORNIA's** state legislature repeals its JUA, while a 1980 **OHIO** statute establishes a Joint Select Committee of both Senate and House members to study the dissolution of the state's JUA. The **OHIO** law further charges the Joint Select Committee with investigating the procedures to be used for monitoring the insurance industry's assumption of JUA's responsibilities.

State-By-State Summary of 1980 Enactments Relating to Malpractice

ALABAMA

SB 111—Makes minor changes in the law governing the issuance of liability insurance by the State Malpractice Insurance Corporation.

CALIFORNIA

AB 1725—This act amends **CALIFORNIA's** existing statute on reciprocal insurers. It permits participating members (physicians and surgeons) to enter into interindemnity arrangements for less than the required $1 million for each occurrence of professional negligence. In addition, any change in the coverage agreement between the interindemnity arrangement and its membership must now be submitted to the entire membership for ratification.

SB 1411—Repeals the Joint Underwriting Association which was created to provide medical malpractice insurance when unavailable through private insurers.

FLORIDA

HB 1094—Sets out the appointed terms of the Board of Governors of the **FLORIDA** Patients' Compensation Fund.

SB 762—Permits a prevailing party in a medical malpractice action to recover a "reasonable" attorney's fee from the losing party.

HAWAII

SB 3003—Under this amendment, the statute of limitations for hearings before the Medical Claims Conciliation Panel is set at 18 months.

KANSAS

SB 61—This act expands the definition of medical care facility to now include any director, trustee, officer, or administrator of a medical care facility. Under the Health Care Provider Insurance Availability Act, these officials are required to obtain liability coverage.

Also subsumed under this amendment are mental health centers and mental health clinics, as well as their officers.

SB 565—Establishes a plan, composed of all insurers who write professional liability insurance, to provide such coverage to applicants who are unable to obtain liability insurance through ordinary methods. Rates must be reasonable and not unfairly discriminatory and each applicant has the right to a hearing on any grievance.

The Commissioner of Insurance is directed to review these plans and disapprove any that fail to meet statutory requirements under the Health Care Provider Insurance Availability Act.

In addition, this law authorizes the Commissioner to appoint a nine-member board to review and prescribe operating rules.

SB 600—Under this act, **KANSAS's** state legislature increases the amount of money to be paid out of the Health Care Stabilization Fund to $300,000 from $150,000. This fund was created to pay any amount due from a judgment or settlement in excess of the basic liability coverage for health care providers.

LOUISIANA

HB 1665—This amendment permits **LOUISIANA** courts to assess losing parties in malpractice actions for the costs of medical reports, copies of hospital records, and for the use of expert witnesses.

MAINE

SB 764—Extends the life of the **MAINE** Medical and Hospital Malpractice Joint Underwriting Association Act until July 1981.

MARYLAND

SB 228—Extends the automatic termination date of the Professional and Executive Liability Fund until June 1, 1982.

HB 1085—Grants immunity from suit to any member of the Health Claims Arbitration Panel during his or her tenure.

MASSACHUSETTS

SB 748—Permits the State Medical Malpractice Joint Underwriting Association to implement a rate increase in order to recoup a previous year's deficit.

MICHIGAN

SB 715—Creates an arbitration system to resolve medical malpractice disputes. Under this law, an arbitration panel consists of three members: an attorney, who acts as chairperson; a physician, preferably from the respondent's medical specialty; and a person who cannot be a lawyer, nor a representative of a hospital or insurance company, nor a licensee of the health profession involved. If a case involves a hospital, only a hospital administrator may be substituted for the physician panelist.

All panelists are selected from a pool of candidates and each party is permitted to strike from a list of five candidates, any name which is unacceptable.

NEW YORK

AB 10239—Extends the life of the State Medical Malpractice Insurance Association for one additional year.

OHIO

HJR 93—This resolution establishes a Joint Select Committee, composed of both Senate and House members, to study the "orderly" termination of the Joint Underwriting Association. The Joint Committee also is charged with investigating the procedures to be used for monitoring the insurance industry's assumption of the JUA's responsibilities.

PENNSYLVANIA

HB 2204—Requires every licensed health care provider to obtain professional liability coverage from licensed or approved insurers only. A health care provider who conducts more than 50 percent of his practice in the state must obtain liability insurance of $100,000 per occurrence and $1,000,000 per annual aggregate. Any health care provider or hospital who obtains this basic liability coverage can participate in the Medical Professional Liability Catastrophe Loss Fund.

This act further creates a contingency fund for paying all awards, judgments, or settlements against a participating health care provider for damages in excess of the basic coverage. The fund is limited to paying $1,000,000 for each occurrence and $3,000,000 per annual aggregate. Each health care provider is assessed an annual charge to reimburse the fund for the payment of claims and expenses. In addition, if the Commissioner of Insurance determines that the fund would be exhausted if all claims were paid, he may assess an emergency surcharge on all participating health care providers.

RHODE ISLAND

HB 7234—Makes a minor change in the selection of special masters who chair the Medical Liability Mediation Panels.

HB 7500—This act stipulates new provisions for the operation of **RHODE ISLAND's** Medical Liability Mediation Panels. Under this amendment, a panel must now be selected within 90 days of the date the action was filed with the Superior Court. In addition, a panel must now conduct its hearing within six months after the parties have notified the panel of completion of discovery proceedings. If the panel cannot meet within this period, then it cannot make any findings and must report the case as incomplete. If the panel can demonstrate good cause, the presiding justice of the Superior Court can grant the panel an additional period, not to exceed three months.

TENNESSEE

SB 2371—Amends existing law relating to the **TENNESSEE** Medical Malpractice Review Board. Under this Act, if both parties agree, they may waive having their malpractice action referred to the Board. In addition, this law now requires that the Board conduct a hearing within six months after an action is filed with a circuit court, and render a decision within 30 days after each hearing. The parties then have 30 days to accept or reject the decision. If the Board does not receive a response within 30 days, then it must presume that the party who fails to respond has rejected the Board's recommendation.

This amendment further precludes the admissibility in evidence of any statement made during the course of the hearing; however, the Board's formal statement is admissible at a subsequent trial.

Each health care provider is assessed a certain annual fee to support the administrative costs of the Board.

VIRGINIA

HB 698—This act prohibits the exclusion of an expert witness's testimony solely because he or she does not practice in the State, so long as he or she is familiar with the statewide standard of care.

HB 793—Sets out the procedures for the "orderly" termination of the Joint Underwriting Association. Under this statute, the JUA is directed to remain in existence solely to complete its dissolution and discharge its obligations. The JUA, however, cannot continue its underwriting functions.

WISCONSIN

SB 565—Makes several minor changes in the operational procedures of the State Patient Compensation Fund.

Intergovernmental Health Policy Project

The Intergovernmental Health Policy Project serves a unique function in the development of the nation's health policy. It is the only university-based program in the country concentrating its research efforts exclusively on the health laws and programs of the 50 state governments. The Project provides assistance to state executive officials, legislators, legislative staff and others who need to know about important developments in other states. At the same time, the IHPP helps federal officials identify innovative state health programs and specific state problems.

To facilitate these information-brokering activities, the IHPP maintains direct links with state governments, state legislatures, research centers, planning agencies, and interest groups throughout the country. Reliable, up-to-date information on health legislation and programs is obtained through IHPP's own network of knowledgeable health policy experts in each of the 50 states, as well as from its clearinghouse of all state health legislation.

Through its newsletter, *State Health Notes*, research publications, and conferences, the IHPP provides key health policy-makers with timely, comprehensive examinations of innovative state legislative activities and health programs.

The Intergovernmental Health Policy Project has a full-time staff of five professional researchers, supplemented by graduate research assistants and consultants. The publications, research and services of the IHPP are made possible by a grant from the Office of Research, Demonstrations and Statistics, Health Care Financing Administration, DHHS, to George Washington University. (HCFA Grant #18-P-97321/3-03)

Suite 505
1919 Pennsylvania Ave., N.W.
Washington, D.C. 20006
(202) 872-1445